CITY OF CHANDLER RETIREE

2007 OPEN ENROLLMENT FORM

Name:	**Retiree #:**
Birthdate: **Social Security:**	
Address:	**Telephone #:**

Address/Telephone Changes:

Email:

BENEFIT INFORMATION

Current Medical Coverage:

☐ **NO CHANGE**	**OR Choose one:**	☐ **I do not elect coverage.**
☐ AETNA HMO	☐ Retiree Only -- $436.44 ☐ Retiree & Spouse -- $728.82	☐ Retiree & Children -- $645.88 ☐ Family -- $1,060.48
☐ AETNA CHOICE POS	☐ Retiree Only -- $530.62 ☐ Retiree & Spouse -- $886.10	☐ Retiree & Children -- $785.24 ☐ Family -- $1,289.30

Current Dental Coverage:

☐ **NO CHANGE**	**OR Choose one:**	☐ **I do not elect coverage.**
Dental Care Plan: Delta Dental of Arizona	☐ Retiree Only -- $46.26 ☐ Retiree & 2 or More Dependents -- $121.28	☐ Retiree & 1 Dependent -- $75.30

Current Vision Coverage:

☐ **NO CHANGE**	**OR Choose one:**	☐ **I do not elect coverage.**
Vision Care Plan: VSP	☐ Retiree Only -- $7.46	☐ Employee & Family -- $15.98

Current Life Insurance Coverage:

☐ **NO CHANGE**	**OR Choose one:**	☐ **I do not elect coverage.**
Basic Life Insurance Plan: Sun Life	☐ DECREASE my coverage amount to: _____	

DEPENDENT INFORMATION: **Complete this section if covering a dependent or deleting a dependent.** Indicate Y/N for coverage selection. Complete the physician and office ID sections **ONLY** for newly elected coverage for dependents. All other PCP Changes should be made by calling Aetna at 1-877-402-8742.

Name	S S #	Birthdate	Sex	Medical Y/N	Primary Care Physician	Office ID#	Dental Y/N	Vision Y/N
Spouse:								
Child:1								
Child:2								
Child:3								

BENEFICIARY DESIGNATIONS FOR: Basic Life, Commuter & Voluntary Term Life (Replaces previous declarations.)

Name	Circle	Relationship	Birthdate	SS#	%	Address & City, State, Zip
	Primary Secondary					
	Primary Secondary					
	Primary Secondary					
	Primary Secondary					
	Primary Secondary					
	Primary Secondary					
	Primary Secondary					

Important information

I hereby apply for coverage under the benefit plans provided by the City, subject to all plan terms, conditions and provisions. My signature on this enrollment form will serve as (1) authorization for release, if necessary, of medical records information for plan benefits for myself and covered dependents, (2) my agreement that the above information is true and correct to the best of my knowledge, and (3) my understanding that waiving any coverage now will prevent me from re-enrolling in that coverage in the future.

Employee Signature: _____ Date: _____